907 KAR 1:025. Payment for services provided by an intermediate care facility for individuals with an intellectual disability, a dually-licensed pediatric facility, an institution for mental diseases, or a nursing facility with an all-inclusive rate unit.

RELATES TO: KRS 142.363, 42 C.F.R. Parts 430, 431, 432, 433, 435, 440, 441, 442, 447, 455, 456, 42 U.S.C. 1396a, b, c, d, g, i, l, n, o, p, r, r-2, r-3, r-5, s

STATUTORY AUTHORITY: KRS 142.363(3), 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the method for determining amounts payable by the Medicaid Program for nursing facility services provided by an intermediate care facility for individuals with an intellectual mental retardation or a developmental disability, a dually-licensed pediatric facility, an institution for mental diseases, or a nursing facility with an all-inclusive rate unit.

Section 1. Definitions. (1) "Allowable cost" means that portion of a facility's cost which may be allowed by the department in establishing the reimbursement rate.

(2) "Calculated rate" means the rate effective July 1, 1999 and each July 1 thereafter for:

(a) An intermediate care facility for individuals with an intellectual mental retardation or a developmental disability (ICF-IID); or

(b) A nursing facility certified as:

1. A dually-licensed pediatric facility; or

2. An institution for mental diseases.

(3) "Cost-based facility" means a facility which:

(a) The department shall reimburse for all allowable costs; and

(b) Is either:

1. A dually-licensed pediatric facility;

2. An intermediate care facility for individuals with an intellectual mental retardation or a developmental disability; or

3. An institution for mental diseases.

(4) "Cost report" means Cost-based Facility Reimbursement Cost Report Instructions and Cost-based Facility Reimbursement Cost Report.

(5) "Department" means the Department for Medicaid Services or its designee.

(6) "Global Insight Index" means an indication of changes in health care costs from year to year developed by Global Insights Index.

(7) "IMD" means an institution for mental diseases, excluding psychiatric hospitals.

(8) "Nursing facility" or "NF" means that:

(a) The state survey agency has:

1. Granted an NF license to a facility; and

2. Recommended the NF to the department for certification as a Medicaid provider; and

(b) The department has granted certification for Medicaid participation to the NF.

(9) "Occupancy factor" means a percentage representing:

(a) A facility’s actual occupancy level; or

(b) A minimum occupancy level assigned to a facility if its occupancy level is below the minimum level established in Section 3(17) of this administrative regulation.

(10) "Prospective rate" means a payment rate for routine services based on allowable costs and other factors which, except as specified in Section 3 of this administrative regulation, shall

not be retroactively adjusted, either in favor of the facility or the department.

(11) "Routine services" means services covered by the Medicaid Program pursuant to 42 C.F.R. 483.10(c)(8)(i).

(12) "State survey agency" means the Cabinet for Health and Family Services, Office of Inspector General, Division of Long-term Care.

(13) "Upper payment limit" means the aggregate payment amount as described in 42 C.F.R. 447.272 for inpatient services furnished by state-owned or operated ICF-IIDs.

Section 2. Certified Bed Requirements. Except for an intermediate care facility for individuals with an intellectual mental retardation or a developmental disability or a nursing facility with an all-inclusive rate unit, a facility which desires to participate in the Medicaid Program shall comply with the following requirements:

(1) If the facility has less than ten (10) beds, all of its beds shall participate in the Medicare Program; or

(2) If the facility has ten (10) or more beds, it shall be required to have the greater of:

(a) Ten (10) of its Medicaid-certified beds participating in the Medicare Program; or

(b) Twenty (20) percent of its Medicaid-certified beds participating in the Medicare Program.

Section 3. Payment System for a Cost-based Facility. The department's reimbursement system shall include the specific policies, components or principles established in this section.

(1)(a) Prospective payment rates for routine services shall be set by the department on a facility-specific basis, and shall not be subject to retroactive adjustment except as specified in this section of this administrative regulation.

(b) Prospective rates shall be determined on a cost basis annually, and may be revised on an interim basis by the department.

(c) An adjustment to a prospective rate (subject to the maximum payment for that type of facility) shall be considered if:

1. The facility's increased costs are attributable to:

a. A governmentally imposed minimum wage increase, staffing ratio increase, or a level of service increase; and

b. The increase was not included in the Global Insight Index;

2. A new licensure requirement or new interpretation of an existing requirement by the appropriate governmental agency as issued in an administrative regulation results in changes that affect all facilities within the class; or

3. The facility experiences a governmentally-imposed displacement of residents.

(d)1. The amount of any prospective rate adjustment resulting from a governmentally-imposed minimum wage increase or licensure requirement change or interpretation as cited in paragraph (c)(2) of this subsection of this paragraph shall not exceed the amount by which the cost increase resulting directly from the governmental action exceeds on an annualized basis the inflation allowance amount included in the prospective rate for the general cost area in which the increase occurs. For purposes of this determination, costs shall be classified into the following two (2) general areas:

a. Salaries; and

b. Other.

2. The effective date of an interim rate adjustment shall be the first day of the month in which the adjustment is requested or in which the cost increase occurred, whichever is later.

(2)(a) The state shall set a uniform rate year for a cost-based facility (July 1 - June 30) by taking the latest available cost data available as of May 16 of each year and trending the facility costs to July 1 of the rate year. If the latest available cost report data has not been audited

or desk-reviewed prior to rate setting for the universal year beginning July 1, a prospective rate based on a cost report which has not been audited or desk-reviewed shall be subject to adjustment when the audit or desk review is completed.

(b) Partial year, or budget cost data shall be used if a full year's date is unavailable. Unaudited reports shall be subject to an adjustment to the audited amount.

(c) Other factors relating to costs.

1. If the department has made a separate rate adjustment as compensation to a facility for a minimum wage update, the department shall:

a. Not pay the facility twice for the same costs; and

b. Adjust downward the trending and indexing factors to the extent necessary to remove from the factors costs relating to the minimum wage updates already provided for by the separate rate adjustment.

2. If the trending and indexing factors include costs related to a minimum wage increase:

a. The department shall not make a separate rate adjustment; and

b. The minimum wage costs shall not be deleted from the trending and indexing factors.

3. The maximum payment amounts for the prospective universal rate year shall be adjusted each July 1 so that the maximum payment amount in effect for the rate year shall be related to the cost reports used in setting the facility rates for the rate year.

4. For purposes of administrative ease in computations, normal rounding shall be used in establishing the maximum payment amount, with the maximum payment amount rounded to the nearest five (5) cents.

(3)(a) Except as provided in paragraph (b) of this subsection, interest expense used in setting a prospective rate shall be an allowable cost if permitted pursuant to 42 C.F.R. 413.153 and if the interest expense:

1. Represents interest on:

a. Long term debt existing at the time the provider enters the program; or

b. New long-term debt, if the proceeds are used to purchase fixed assets relating to the provision of the appropriate level of care.

(i) If the debt is subject to variable interest rates found in balloon-type financing, renegotiated interest rates shall be allowable; and

(ii) The form of indebtedness may include mortgages, bonds, notes, and debentures if the principal is to be repaid over a period in excess of one (1) year; or

2. Is for working capital and operating needs that directly relate to providing patient care. The form of indebtedness may include notes, advances and various types of receivable financing.

(b) Interest on a principal amount used to purchase goodwill or other intangible assets shall not be considered an allowable cost.

(4) The allowable cost for a service or good purchased by a facility from a related organization shall be the cost to the related organization, unless it can be demonstrated that the related organization is equivalent to a second party supplier.

(a) Except as provided in paragraph (b) of this subsection, an organization shall be considered a related organization if an individual possesses five (5) percent or more of ownership or equity in the facility and the supplying business.

(b) An organization shall not be considered a related organization if fifty-one (51) percent or more of the supplier's business activity of the type carried on with the facility is transacted with persons and organizations other than the facility and its related organizations.

(5)(a) Except as provided in paragraph (b) of this subsection, the amount allowable for leasing costs shall not exceed the amount which would be allowable based on the computation of historical costs.

(b) The department shall determine the allowable costs of an arrangement based on the costs of the original lease agreement if:

1. A cost-based facility entered into a lease arrangement as an intermediate care facility prior to April 22, 1976;

2. An intermediate care facility for individuals with an intellectual mental retardation or a developmental disability entered into a lease arrangement prior to February 23, 1977; or

3. A nursing facility entered into a lease arrangement as a skilled nursing facility prior to December 1, 1979.

(6) A cost shall be allowable and eligible for reimbursement if the cost is:

(a) Reflective of the provider's actual expenses of providing a service; and

(b) Related to Medicaid patient care pursuant to 42 C.F.R. 413.9.

(7) The following costs shall be allowable:

(a) Costs to related organizations pursuant to 42 C.F.R. 413.17;

(b) Costs of educational activities pursuant to 42 C.F.R. 413.85;

(c) Research costs pursuant to 42 C.F.R. 413.90;

(d) Value of services of nonpaid workers pursuant to 42 C.F.R. 413.94;

(e) Purchase discounts and allowances, and refunds of expenses pursuant to 42 C.F.R. 413.98;

(f) Depreciation on buildings and equipment if a cost is:

1. Identifiable and recorded in the provider's accounting records;

2. Based on historical cost of the asset or, if donated, the fair market value; or

3. Prorated over the estimated useful life of the asset using the straight-line method;

(g) Interest on current and capital indebtedness; or

(h) Professional costs of services of full-time or regular part-time employees not to exceed what a prudent buyer would pay for comparable services.

(8) The following shall not be allowable costs:

(a) The value of services provided by nonpaid members of an organization if there is an agreement with the provider to furnish the services at no cost;

(b) Political contributions;

(c) Legal fees for unsuccessful lawsuits against the Cabinet for Health and Family Services;

(d) Travel and associated costs outside the Commonwealth of Kentucky to conventions, meetings, assemblies, conferences or any related activities that are not related to NF training or educational purposes; or

(e) Costs related to lobbying.

(9) To determine the gain or loss on the sale of a facility for purposes of determining a purchaser's cost basis in relation to depreciation and interest costs, the following methods shall be used for changes of ownership occurring before July 18, 1984:

(a)1. Determine the actual gain on the sale of the facility; and

2. Add to the seller's depreciated basis two-thirds (2/3) of one (1) percent of the gain for each month of ownership since the date of acquisition of the facility by the seller to arrive at the purchaser's cost basis;

(b) Gain shall be the amount in excess of a seller's depreciated basis as computed under program policies at the time of a sale, excluding the value of goodwill included in the purchase price;

(c) A sale shall be any bona fide transfer of legal ownership from an owner to a new owner for reasonable compensation, which shall usually be fair market value. A lease purchase agreement or other similar arrangement which does not result in a transfer of legal ownership from the original owner to the new owner shall not be considered a sale until legal ownership of the property is transferred; and

(d) If an enforceable agreement for a change of ownership was entered into prior to July 18, 1984, the purchaser's cost basis shall be determined pursuant to paragraphs (a) through (c) of this subsection.

(10) Valuation of capital assets.

(a) An increase in valuation in relation to depreciation and interest costs shall not be allowed for changes of ownership occurring after July 18, 1984 and before October 1, 1985.

(b) For bona fide changes of ownership entered into on or after October 1, 1985, the depreciation and interest costs shall be increased in valuation in accordance with 42 U.S.C. 1395x(v)(1)(O)(i).

(11)(a) A facility shall maintain and make available any records and data necessary to justify and document:

1. Costs to the facility; and

2. Services performed by the facility; and

(b) The department shall have unlimited on-site access to all of a facility's fiscal and service records for the purpose of:

1. Accounting;

2. Auditing;

3. Medical review;

4. Utilization control; and

5. Program planning.

(12) The following shall apply to an annual cost report:

(a) A year-end cost report shall contain information relating to prior year cost, and shall be used in establishing prospective rates and setting ancillary reimbursement amounts;

(b) A new item or expansion representing a departure from current service levels for which the facility requests prior approval by the department shall be so indicated with a description and rationale as a supplement to the cost report;

(c) Department approval or rejection of a projection or expansion shall be made on a prospective basis in the context that if an expansion and related costs are approved they shall be considered when actually incurred as an allowable cost. Rejection of an item or costs shall represent notice that the costs shall not be considered as part of the cost basis for reimbursement. Unless otherwise specified, approval shall relate to the substance and intent rather than the cost projection; and

(d) If a request for prior approval of a projection or expansion is made, absence of a response by the department shall not be construed as approval of the item or expansion.

(13)(a) The department shall perform a desk review of each year-end cost report and ancillary service cost to determine the necessity for and scope of an audit in relation to routine and ancillary service cost;

(b) If a field audit is not determined to be necessary, the cost report shall be settled without an audit;

(c) A desk review or field audit shall be used for purposes of verifying cost to be used in setting the prospective rate or for purposes of adjusting prospective rates which have been set based on unaudited data; and

(d) Audits may be conducted annually or at less frequent intervals.

(14) A year-end adjustment of the prospective rate and a retroactive cost settlement shall be made if:

(a) An incorrect payment has been made due to a computational error (other than an omission of cost data) discovered in the cost basis or establishment of the prospective rate;

(b) An incorrect payment has been made due to a misrepresentation on the part of a facility (whether intentional or unintentional);

(c) A facility is sold and the funded depreciation account is not transferred to the purchaser; or

(d) The prospective rate has been set based on unaudited cost reports and the prospective rate is to be adjusted based on audited reports with the appropriate cost settlement made to adjust the unaudited prospective payment amounts to the correct audited prospective payment amounts.

(15) A facility shall provide the services mandated in 42 C.F.R. 483.10(c)(8)(i).

(16) A facility shall submit to the department the data required for determining the prospective rate no later than sixty (60) days following the close of the facility's fiscal year. This time limit may be extended at the specific request of the facility with the department's concurrence.

(17) Allowable prior year cost, trended to the beginning of the rate year and indexed for inflation, shall be subject to adjustment based on a comparison of costs with a non-state, privately-owned facility's occupancy factor.

(a) An occupancy factor shall not be less than actual bed occupancy, except that it shall not exceed ninety-eight (98) percent of certified bed days (or ninety-eight (98) percent of actual bed usage days, if more, based on prior year utilization rates).

(b) A minimum occupancy factor shall be ninety (90) percent of certified bed days for nonstate, privately-owned facilities with less than ninety (90) percent certified bed occupancy.

(c) The department may impose a lower occupancy factor for a newly constructed or newly participating nonstate, privately-owned facility, or for an existing nonstate, privately-owned facility suffering a patient census decline as a result of a newly constructed or opened competing facility serving the same area.

(d) The department may impose a lower occupancy factor during the first two (2) full fiscal years an existing cost-based nonstate, privately-owned facility participates in the program under this payment system.

(18) A provider tax on a cost-based facility shall be considered an allowable cost.

(19) All other costs shall be:

(a) Other care-related costs;

(b) Other operating costs;

(c) Capital costs; or

(d) Indirect ancillary costs.

(20) Basic per diem costs for each major cost category (nursing services costs and all other costs) shall be the calculated rate arrived at after otherwise allowable costs are trended and adjusted in accordance with the:

(a) Global Insight Index inflation factor; and

(b) Occupancy factor for a nonstate, privately owned facility.

(21) Maximum allowable costs shall be the maximum amount which may be allowed to a facility as reasonable cost for the provision of a supply or service while complying with limitations expressed in related federal or state regulations.

(22) Nursing services costs shall be the direct costs associated with nursing services.

(23) State-owned or operated ICF-IID reimbursement for noncapital routine services shall be subject to an upper payment limit. The upper payment limit shall:

(a) Be an aggregate limit on ICF-IID reimbursement paid by the department;

(b) Equal 112 percent of the average of aggregate cost for a state fiscal year;

(c) Be revised annually by the Global Insight Index using the most recent full year of Medicaid paid days;

(d) Not be rebased more frequently than every three (3) years; and

(e) Use as its base year the State Fiscal Year 2005.

(24) The department shall retroactively cost settle state-owned or operated ICF-IID reimbursement for non-capital routine services beginning with the cost report period November 1, 2005 through June 30, 2006, as mandated by the Centers for Medicare and Medicaid Services in accordance with 42 U.S.C. 1396a(a)(30). Retroactive settlement shall entail:

(a) Comparing interim payments with the properly apportioned cost of Medicaid services rendered. Cost report data shall be used to determine properly apportioned costs;

(b) A tentative cost report settlement based upon:

1. Eighty (80) percent of any amount due the facility after a preliminary review is performed; or

2. 100 percent settlement of any liability due the department; and

(c) A final cost report settlement after the allowed billing period has elapsed for the dates of service identified within the cost report.

(25) The department, regarding state-owned or operated ICF-IID reimbursement for noncapital routine services shall:

(a) Use projected data in order to approximate as closely as possible an interim rate expected to correspond to postsettlement cost; and

(b) Adjust interim rates up or down if necessary to approximate a rate corresponding as close as possible to anticipated postsettlement cost.

Section 4. Prospective Rate Computation for a Cost-based Facility. The prospective rate for a cost-based facility shall reflect the following:

(1) The adjusted allowable cost for the facility; and

(2) Except for a state-owned or operated facility, the facility's occupancy factor. A state-owned or operated facility's occupancy factor shall not be factored into the facility's prospective rate.

Section 5. Ancillary Services. (1) Except for an intermediate care facility for individuals with an intellectual mental retardation or a developmental disability, an ancillary service shall be a direct service for which a charge is customarily billed separately from a per diem rate including:

(a) Ancillary services pursuant to 907 KAR 1:023; or

(b) Laboratory procedures or x-rays if ordered by a:

1. Physician;

2. An advanced registered nurse practitioner (ARNP) if the laboratory test or x-ray is within the scope of the ARNP's practice; or

3. Physician assistant if:

a. Authorized by the supervising physician; and

b. The laboratory test or x-ray is within the scope of the physician assistant's practice.

(2) For an intermediate care facility for individuals with an intellectual mental retardation or a developmental disability, an ancillary service shall be a direct service for which a charge is customarily billed separately from a per diem rate including:

(a) Ancillary services identified in 907 KAR 1:023;

(b) Laboratory procedures or x-rays if ordered by a:

1. Physician;

2. An ARNP if the laboratory test or x-ray is within the scope of the ARNP's practice; or

3. Physician assistant if:

a. Authorized by the supervising physician; and

b. The laboratory test or x-ray is within the scope of the physician assistant's practice; or

(c) Psychological or psychiatric therapy.

(3) Ancillary service.

(a) Reimbursement shall be subject to a year-end audit, retroactive adjustment, and final settlement.

(b) Costs shall be subject to allowable cost limits pursuant to 42 C.F.R. 413.106.

(4) For ancillary services, the department shall utilize an NF's prior year cost-to-charge ratio, based on the prior year's cost report as of May 31, as the percentage to be used for interim reimbursement purposes for the following year. (For example if an NF's cost-to-charge ratio for SFY 2001 is seventy-five (75) percent, the department shall reimburse the NF, on an interim basis, seventy-five (75) percent of billed charges for SFY 2002.)

(5) An NF without a prior year cost report may submit to the department a percentage to be used for interim reimbursement purposes for ancillary services.

(6) If an NF has been reimbursed for ancillary services at an interim percentage above its allowable cost-to-charge ratio for a given year, the department shall decrease the interim percentage for the following year by no more than twenty-five (25) percentage points unless:

(a) A retroactive adjustment of an NF's reimbursement for the prior year reveals an overpayment by the department exceeding twenty-five (25) percent of billed charges; or

(b) An evaluation of an NF's current billed charges indicates that the NF's charges exceed, by greater than twenty-five (25) percent, average billed charges for other comparable facilities serving the same area.

Section 6. Reimbursement for a Nursing Facility With a Distinct Part Ventilator Unit. (1) A nursing facility recognized as providing distinct part ventilator dependent care shall be paid at an all-inclusive (excluding drugs which shall be reimbursed through the pharmacy program) fixed rate for services provided in the distinct part ventilator unit.

(2) A distinct part ventilator unit shall:

(a) Have a minimum of twenty (20) beds;

(b) Maintain a census of fifteen (15) patients; and

(c) Base the patient census upon:

1. The quarter preceding the beginning of the rate year; or

2. The quarter preceding the quarter for which certification is requested if the facility did not qualify for participation as a distinct part ventilator care unit at the beginning of the rate year.

(3)(a) The fixed rate for a hospital-based facility shall be $583.82 per day.

(b) The department shall reimburse a freestanding facility:

1. A fixed rate of $317.29 per day; and

2. An add-on to the fixed rate in accordance with KRS 142.363.

(4) The fixed rates established in subsection (3) of this section shall be increased or decreased based on the Data Resource Incorporated rate of inflation indicator for the nursing facility services for each rate year.

(5) Costs of distinct part ventilator nursing facility units shall be excluded from allowable costs for purposes of rate setting and settlement of cost-based nursing facility cost reports.

Section 7. Reimbursement for a Nursing Facility with a Brain Injury Unit. (1) In order to participate in the Medicaid Program as a brain injury provider, a nursing facility with a distinct part brain injury unit shall:

(a) Be Medicare and Medicaid certified;

(b) Designate as a brain injury unit at least ten (10) certified beds that are physically contiguous and identifiable;

(c) Be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) after the first year of participation; and

(d) Establish written policies regarding administration and operations, the facility's governing

authority, quality assurance, and program evaluation.

(2) Except as provided in subsection (3) of this section, a nursing facility with a Medicaid certified brain injury unit providing preauthorized specialized rehabilitation services for persons with brain injuries shall be paid at an all-inclusive (excluding drugs which shall be reimbursed through the pharmacy program) fixed rate which shall be set at $475 per diem for services provided in the brain injury unit.

(3) A facility providing preauthorized specialized rehabilitation services for persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae shall be paid an all-inclusive (excluding drugs which shall be reimbursed through the pharmacy program) negotiated rate which shall not exceed the facility's usual and customary charges.

Section 8. Appeal Rights. A participating facility may appeal department decisions as to the application of this administrative regulation as it impacts the facility's reimbursement in accordance with 907 KAR 1:671, Sections 8 and 9.

Section 9. Reimbursement for Required Services Under the Preadmission Screening Resident Review (PASRR) for a Nursing Facility With a Ventilator Unit, a Nursing Facility With a Brain Injury Unit, an IMD, or a Dually-licensed Pediatric Facility.

(1) Prior to an admission of an individual, a facility shall conduct a level I PASRR in accordance with 907 KAR 1:755, Section 4.

(2) The department shall reimburse a facility for a service delivered to an individual if the facility complies with the requirements of 907 KAR 1:755.

(3) Failure to comply with 907 KAR 1:755 may be grounds for termination of a facility's participation in the Medicaid Program.

Section 10. Reimbursement Provisions. (1) Each of the following types of facilities participating in the Medicaid Program shall be reimbursed in accordance with this administrative regulation:

(a) A nursing facility with a certified brain injury unit;

(b) A nursing facility with a distinct part ventilator unit;

(c) A nursing facility designated as an institution for mental diseases;

(d) A dually-licensed pediatric facility; or

(e) An intermediate care facility for individuals with an intellectual mental retardation or a developmental disability.

(2) A payment made to a facility governed by this administrative regulation shall:

(a) Be made in accordance with the requirements established in 907 KAR 1:022; and

(b) Be subject to the limits established in 42 C.F.R. 447.272.

Section 11. Supplemental Payments to Dually-licensed Pediatric Facilities. (1) Beginning July 1, 2002 and annually thereafter, the department shall establish a pool of $550,000 to be distributed to facilities qualifying for supplemental payments in accordance with subsection (2) of this section.

(2) Based upon its pro rata share of Medicaid patient days compared to total patient days of all qualifying facilities, a dually-licensed pediatric facility shall qualify for a supplemental payment if:

(a) Funding is available; and

(b) The facility:

1. Is located within the Commonwealth of Kentucky;

2. Has a Medicaid occupancy rate at or above eighty-five (85) percent;

3. Only provides services to children under age twenty-one (21); and

4. Has forty (40) or more licensed beds.

(3) A supplemental payment to a facility meeting the criteria established in subsection (2) of this section shall:

(a) Apply to services provided on or after July 1, 2002;

(b) Be made on a quarterly basis; and

(c) Not be subject to the cost settlement provisions established in Section 3 of this administrative regulation.

Section 12. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Cost-based Facility Reimbursement Cost Report Instructions", April 2000 Edition; and

(b) "Cost-based Facility Reimbursement Cost Report", April 2000 Edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, 6th Floor West, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (17 Ky.R. 2358; 2748; 2963; eff. 3-12-91; 18 Ky.R. 915; eff. 10-16-91; 19 Ky.R. 827; eff. 11-9-92; 1922; 2281; 2453; eff. 4-21-93; 20 Ky.R. 441; eff. 10-13-93; 21 Ky.R. 674; eff. 9-21-94; 3079; 22 Ky.R. 749; eff. 9-20-95; 26 Ky.R. 2045; 27 Ky.R. 126; eff. 7-17-2000; 29 Ky.R. 1122; 1643; eff. 12-18-02; 31 Ky.R. 1445; 1671; eff. 4-22-05; 32 Ky.R. 1184; 1427; eff. 3-3-06; 33 Ky.R. 3297; 4186; eff. 7-6-2007; TAm 7-16-2013.)